907 KAR 1:025

Payment for services provided by an intermediate care facility for the mentally retarded and developmentally disabled, a dually-licensed pediatric facility, an institution for mental diseases, a nursing facility with an all-inclusive rate unit.

Material Incorporated by Reference

Cost-based Facility Reimbursement Cost Report Instructions, April 2000 Edition (clean)

Cost-based Facility Reimbursement Cost Report, April 2000 Edition (clean)

MAP-703, Request for Reconsideration Ancillary Therapy Billing, April 2000 Edition (dirty)

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COMMONWEALTH OF KENTUCKY

Cabinet for Health Services

Department for Medicaid Services

COST-BASED FACILITY

COST REPORT INSTRUCTIONS

Edition 4/00

COST-BASED FACILITY COST REPORT INSTRUCTIONS

INTRODUCTION TO THE COST-BASED FACILITY COST REPORT:

The Annual Cost-Based Facility Cost Report provides for the submission of cost and statistical data which shall be used in rate setting and in reporting to various governmental and private agencies. All required information is pertinent and shall be submitted as accurately as possible.

In general, costs shall be reported as they appear in the provider's accounting records. Schedules shall be provided for any adjustments or reclassifications that are necessary.

In the cost finding process, direct costing between Certified Cost-Based Facility (CNF) and Non-certified Cost-Based Facility (non-CNF) shall be used wherever possible. If direct costing is utilized, it shall be utilized, if possible, for all costs of a similar nature. Direct costing shall not be utilized on a selective basis in order to distort the cost finding process.

SCHEDULE A - CERTIFICATION AND OTHER DATA:

This schedule shall be completed by all facilities.

A. TYPE OF CONTROL. In Sections 1 through 3 indicate as appropriate the ownership or auspices under which the facility operates.

B. Section B is provided to show whether the amount of costs to be reimbursed by the Medicaid Program includes costs resulting from services, facilities, and supplies furnished to the vendor by organizations related to the vendor by common ownership or control.

Section B shall be completed by all vendors.

C. Section C shall be completed when the answer in Part B is yes. The amount reported in Section C shall agree with the facility's books.

D. Section D shall be completed when the answer in Part B is yes.

E. Section E is provided to show the total compensation paid for the period to sole proprietors, partners, and corporation officers, as owner(s) of Certified Nursing Facilities. Compensation is defined in the Principles of Reimbursement as the total benefit received (or receivable) by the owner for the services he renders to the institution. It shall include salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the institution for the personal benefit of the owner; and the cost of assets and services which the owner receives from the institution and deferred compensation. List the name, title and function of owner(s), percent of work week devoted to business, percent of stock owned, and total compensation.

F. Section F is provided to show total compensation paid to each employed person(s) to perform duties as administrators or assistance administrators. List each administrator or assistance administrator who has been employed during the fiscal period. List the name, title, percent of customary work week devoted to business, percent of the fiscal period employed, and total compensation for the period.

G. Section G shall be completed by all providers.

H. Section H shall be completed by all providers.

COST-BASED FACILITY COST REPORT INSTRUCTIONS

SCHEDULE B - STATEMENT OF INCOME AND EXPENSES:

If a facility has an income statement which provides the same detail as this schedule, this statement may be submitted in lieu of Schedule B. This schedule shall be prepared for the reporting period. During preparation, consideration shall be given to the following items :

A. Line 1. The amount entered on this line shall be the gross charges for services rendered to patients before reductions for charity, bad debts, contractual allowances, etc.

B. Line 2. Record total bad debts, charity allowances, contractual adjustments, etc. on this line. This line shall include the difference between amounts paid by the patient or 3rd party payor and the standard charge of the facility.

C. Line 3. Subtract line 2 from line 1.

D. Line 4. Enter total operating expenses from Schedule D-4, Line 26, Column 2.

E. Line 5. Subtract line 4 from line 3.

F. Lines 6a, 6b, 7a, and 7b. Complete these lines in accordance with the definitions of restricted and unrestricted as presented in the Principles of Reimbursement in this manual.

G. Line 12. Include on this line rent received from the rental portions of a facility to other related or non-related parties, i.e., the rental of space to a physician, etc.

H. Line 14. Purchase discounts shall be applied to the cost of the items to which they relate.

However, if they are recorded in a separate account, the total of the discounts shall be entered on this line.

I. Line 31. Total lines 6a through 30.

J. Line 33-48. Enter amount of other expenses, including those incurred by the facility which do not relate to patient care.

K. Line 49. Total lines 33 through 48.

L. Line 50. Subtract line 49 from line 32.

SCHEDULE C -BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

Non-profit facilities shall complete only column 1. Proprietary facilities shall complete the entire schedule.

A. Column l. Enter the balance recorded in the facility's books of accounts at the end of the reporting period (accrual basis of accounting is required as indicated in the Principles of Reimbursement). Attachments may be used if the lines on the schedule are not sufficient. The capital accounts shown on lines 41 through 45, are those applicable to the type of business organization under which the provider operates as follows:

Individual Proprietor - Proprietor's Capital Account

Partnership - Partner's Capital Accounts

Corporation - Capital Stock and Other Accounts

B. Column 2. This column shall be used to show amounts of assets and liabilities included in a facility's balance sheet which do not relate to the provider of patient

care. Entries to this column shall be detailed on Schedule C-1. NOTE: It shall not be necessary to attempt to remove the portion of assets applicable to other levels of care on this schedule. Some examples of adjustments which may be required include:

1. Line 2 - Notes and Accounts Receivable. The notes and accounts receivable total to be entered in column 2 shall represent total amounts expected to be realized by the provider from non-patient care services.
2. Lines 11, 13, 15, 17, 19 - Fixed Assets. The amounts to be entered in column 2 shall be based on the historical cost of those assets, or in the case of donated assets, the fair market value at the time of donation, which are not related to patient care.
3. Line 12, 14, 16, 18, 20 - Accumulated Depreciation. The amounts in column 2 shall be the adjustment necessary to reflect accumulated depreciation on the straight-line method to the effective date of entry into this reimbursement program and amounts claimed thereafter, and shall also be adjusted for disposals and amounts of accumulated depreciation on assets not related to patient care. Assets not related to patient care shall be removed on lines 11, 13, 15, 17, and 19 respectively.
4. LINE 22 - INVESTMENTS. Investments includable in the equity capital balance sheet in column 3 shall be limited to those related to patient care. Primarily, these shall be temporary investments of excess operating funds. Operating funds invested for long periods of time shall be considered

excess and not related to patient care needs and shall accordingly be removed in column 2.

5. LINE 25 - OTHER ASSETS. Examples of items which may be in this asset category and their treatment for equity capital purposes are as follows:

   a. Goodwill purchased shall be includable in equity capital.

   b. Organization Expense. Expenses incurred in organizing the business shall be] includable in equity capital. (Net of Amortization)

   c. Discounts on Bonds Payable. This account represents a deferred charge to income and shall be includable in equity capital.

   Other asset amounts not related to patient care shall be removed in column 2.

5. LINES 37, 38 - LOANS FROM OWNERS. Do not make adjustments in column 2 with respect to funds borrowed by basic IC or IC/MR facilities prior to July 1, 1975 or by Skilled Nursing Facilities prior to December 1, 1979, provided the terms and conditions of the loan agreement have not been modified subsequent to July 1, 1975, or December 1, 1979, respectively. Such loans shall be considered a liability in computing

equity capital as interest expense related to such loans is included in allowable costs.

6. If the terms and conditions of payment of loans made prior to July l, 1975 for IC facilities and December 1, 1979 for Skilled Nursing facilities, have been modified subsequent to July 1, 1975 and December 1, 1979, respectively, such loans shall not be included as a liability in column 6, and therefore shall be adjusted in column 5. Loans made by owners after these dates shall also treated in this manner.

C. For Schedule C, line 1-45, adjust the amounts entered in column 1 (increase and decrease) by the amounts entered in column 2 and extend the net amounts to column 3. Column 3 is provided for the listing of the balance sheet amounts which represent equity capital for the Department for Medicaid Services purposes at the end of the reporting period.

SCHEDULE C-1 - ADJUSTMENT TO EQUITY CAPITAL

This schedule shall be used to explain all adjustments made by the facility on Schedule C, column 2, in order to arrive at the adjusted balance sheet for equity capital purposes.

OVERVIEW OF THE ALLOCATION PROCESS - SCHEDULE D-1 THROUGH D-5

These schedules provide for separating the operating expenses from the facility's financial records into five (5) cost categories: 1) Nursing Services Costs, 2) Other Care Related Costs, 3) Other Operating Costs, 4) Capital Costs and 5) Ancillary Costs. These

schedules also provide for any necessary adjustments and reclassifications to certain accounts. Schedules D-1 through D-5 shall be completed by all facilities. All accounts that can be identified as belonging to a specific cost center shall be reported to the appropriate section of Schedules D-1 through D-5. Capital cost shall be reported on schedule D-4 and not allocated to specific cost centers.

All listed accounts will not apply to all providers and some providers may have accounts in addition to those listed. These shall be listed on the lines labeled "Other Expense."

The flow of the Schedules D-1 through D-4 is identical. Salaries shall be reported on the salaries lines and all salaries for each cost center shall be sub-totaled on the appropriate line. The entries to the columns on these schedules shall be as follows:

A. Column 2. The expenses in this column shall agree with the provider's accounting books and records.

B. Column 3. This column shall be utilized for reclassification of expenses as appropriate. Such reclassifications shall be detailed on Schedule D-6.

C. Column 4. This column shall be for adjustments to allowable costs as may be necessary in accordance with the general policies and principles. All adjustments shall be detailed on Schedule D-7.

D. Column 5. Enter the sum of columns 2, 3, and 4.

E. Column 6. This column shall be completed for each line for which an entry is made to column 5 in order to indicate the basis of the separation of the costs reported to Column 5 between Column 7 (Certified Cost-Based Facility

Alloc. of Costs) and Column 8 (Non-Certified and Non-Cost-Based Facility Alloc. of Costs). A "D" shall be entered to this column on each line on which the adjusted costs (Column 5) are direct costed between Columns 7 and 8. An "A" shall be entered to this column on each line on which the adjusted costs in Column 5 are allocated between Columns 7 and 8 on the basis of the allocation ratios on Schedule F. All accounts which can be direct costed from the provider's records shall be directed costed to Columns 7 and 8. Accounts which are direct costed shall be direct costed in full. Any accounts which cannot be direct costed shall be allocated using statistics from Schedule F. Providers shall ensure that all costs which are reported to column 7 are reasonable, necessary and related to Certified Cost-Based Facility patient care.

F. Columns 7 and 8. The adjusted balance figures from Column 5 are to be allocated between Certified Cost-Based Facility Costs (Column 5) and Non-Certified Non-Facility costs (Column 7). Any accounts that cannot be direct costed shall be allocated using statistics from Schedule F. All costs entered to Column 7 shall be reviewed by the provider to ensure that they are necessary, reasonable and related to Certified Cost-Based Facility patient care.

G. Column 9: This column shall be completed only by Hospital-Based providers. Instructions regarding this column can be found in the instructions for the Schedules which include Column 9 (i.e. D-3 and D-4).

SCHEDULE D-1 - NURSING SERVICES COST

A. The costs associated with nursing services which shall be included in the nursing service cost category are as follows:

1. nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;

2. bedside care and services;

3. administration of oral, sublingual, rectal and local medications topically applied, and appropriate recording of the resident's responses;

4. training, assistance, and encouragement for self-care as required for feeding, grooming. ambulation, toilet, and other activities of daily living including movement within the nursing home facility;

5. supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;

6. care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;

7. administration of oxygen;

8. use of nebulizers;

9. maintenance care of resident's colostomy, ileostomy, and urostomy;

10. administration of parenteral medications, including intravenous solutions;
11. administration of tube feedings;
12. nasopharyngeal aspiration required for maintenance of a clean airway;
13. care of suprapubic catheters and uretheral catheters;
14. care of tracheostomy, gastrostomy, and other tubes in a body;
15. costs of equipment and supplies that are used to complement the services in the nursing service cost category including incontinence pads, dressings, bandages, enemas, enema equipment, diapers, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents;
16. costs for education or training including the cost of lodging and meals of nursing service personnel;
17. the salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
18. the salaries or fees of medical directors, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and
19. the costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification, or professional standards.

B. If an account can be direct costed between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Nursing Facility Costs). Any account that is direct costed shall be directed costed in full. Any account which cannot be direct costed shall be allocated using Schedule F, Statistic A. Multiply the Column 5 amount by the Certified Cost-Based Facility percentage from Schedule F, Statistic A, and enter the product in Column 7. Subtract Column 7 from Column 5 and enter the result in Column 8. Providers shall ensure that all costs reported to Column 7 are necessary, reasonable, and related to Certified Cost-Based Facility patient care.

SCHEDULE D-2 - OTHER CARE RELATED COSTS

A. General

The costs which shall be reported in the other care-related services cost category include:

1. food costs, not including preparation;
2. direct costs of other care-related services, such as social services and patient activities;
3. the salaries and wages of activities directors and aides, social workers and aides, and other care-related personnel including salaries or fees of

professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid Program;

4. the costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties.

B. Specific Instructions

1. Lines 1-30: If an account can be direct costed between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non- Cost-Based Facility Costs.) Any account which is direct costed shall be direct costed in full. If accounts cannot be direct costed, use the nursing allocation percentage (Schedule F, Statistic A, Line 3) to calculate Certified Nursing Facility Other Care Related Costs. Multiply the Certified Cost-Based Facility percentage times the amount in Column 5 and enter the products in Column 7. Subtract Column 7 from Column 5 and enter the results in Column 8.

2. Line 31 : If an account can be direct costed between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the

amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Cost-Based Facility Costs.) Any account which is direct costed between Certified Cost-Based Facility and Non-Certified Cost-Based Facility shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the dietary allocation percentage (Schedule F, Statistic C, Line 1, Column 2). Multiple the Certified Cost-Based Facility percentage times the amount in Column 5 and enter the product in Column 7. Subtract the amount in Column 7 from Column 5 and enter the result in Column 8.

SCHEDULE D-3 - OTHER OPERATING COSTS

A. Lines 1 through 19: If an account can be direct costed between Certified Cost-Based Facility and Non-Certified Cost-Based Facility , the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Cost-Based Facility Costs.) Any account which is direct costed shall be direct costed in full. If an account cannot be direct costed, use the dietary allocation percentage (Schedule F, Statistic C, Line 1, Column 2) to allocate Dietary Costs. Multiply the Certified Cost-Based Facility percentage times the amounts in

Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.

B. Lines 21 through 55: [-] If an account can be direct costed, between Certified Cost-Based Facility and Non-Certified Cost-Based Facility , the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Cost-Based Facility Costs.) Any account which is direct costed shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the Certified Cost-Based Facility square foot percentage (Schedule F, Statistic B, Line 1, Column 2). Multiply the percentage times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage (Schedule F, Statistic B, Line 2, Column 2) times the amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square foot percentages (Schedule F, Statistic B, Lines 3 through 8, Column 2) together. Use the sum to allocate Housekeeping & Plant Operation costs of the ancillary cost centers to Column 9.

C. Line 57 through 74 and 76 through 130: [-] If an account can be direct costed between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s), (either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and

Non-Cost-Based Facility Costs.) If an account cannot be direct costed, use the nursing allocation- percentage (Schedule F, Statistic A, Line 3) to calculate Certified Cost-Based Facility Laundry and Administrative & General costs. Multiply the Certified Cost-Based Facility percentage times amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.

SCHEDULE D-4 - CAPITAL COSTS

A. If an account can be direct costed, between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Cost-Based Facility Costs.) If an account cannot be direct costed, allocate capital costs using square footage (Schedule F, Statistic B, Column 2). Multiply the Certified Cost-Based Facility percentage on Line 1 times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage on Line 2 times amounts in Column 5 and enter the products in Column 8.. For Hospital-Based Facilities only: add the ancillary square footage percentages from Schedule F, Statistic B (Lines 3 through 8, Column 2) together. Use the sum to allocate capital costs of the ancillary cost centers to Column 9.

B.

B. Lines 24 through 28 are provided for the computation of total costs per books, net reclassifications, net adjustments, and total adjusted costs for comparison and analysis.

1. Line 24: The entries to this line Columns 2 through 9 shall be the total of the entries to Columns 2 through 9 of Schedules D-1 through D-3 and D-4 through Line 22.

2. Line 25, Column 7: The entry to this line shall be the sum of Schedule D-5, Column 8, Lines 12, 21, 30, 42, 51, 60, and 67.

3. Line 26, Column 7: The entry to this line shall be the sum of Column 7, Lines 24 and 25.

4. Line 27: The entries to this line columns 2 through 5 shall be the total of the entries to columns 2 through 5 of Schedule D-5. Add the entries from the appropriate column, Schedule D-5, Lines 12, 21, 30, 42, 51, 60 and 67 to compute the proper entry.

5. Line 28: The entries to this line shall be the totals of lines 24 and 27.

   a. Column 2: The amount entered to Line 26, Column 2 shall agree with the total costs of the facility as reported in its general ledger.

   b. Column 3: The total reclassifications (the amount entered to Line 26, Column 3) shall net out to be zero (0).

   c. Column 4: The amount entered to Line 26, Column 4 shall be the total of all adjustments entered to Scheduled D-1 through D-5. It

shall agree with the total adjustments reported on Schedule D-7 (D-7, Line 53, Column 3).

SCHEDULE D-5- ANCILLARY COSTS

A. Column 2: Ancillary costs as shown in the provider's books shall be entered to the appropriate lines. All ancillary salaries shall be reported to the salaries lines and sub-totaled on the appropriate line.

B. Column 3: This column shall be utilized for reclassification of Column 2 costs as may be necessary for compliance with the general policies and principles. Reclassifications shall be detailed on Schedule D-6.

C. Column 4: This column shall be utilized for adjustments to allowable ancillary costs as may be necessary for compliance with the general policies and principles. Adjustments shall be detailed on Schedule D-7.

D. Column 5: Enter the sum of Columns 2, 3, and 4. The amount entered here shall be the total ancillary cost of the facility as defined by the general policies and procedures.

E. Column 6: The cost entered to Column 5 shall be analyzed to identify the direct and indirect ancillary cost portions as defined in the general policies and principles. The direct ancillary cost shall be entered to Column 6.

F. Column 7:

1. This column shall be utilized to report the indirect ancillary portion (as defined in the general policies and principles) of the amount entered to Column 5. Subtract Column 6 from Column 5 and enter the difference.

2. Lines 11, 20, 29, 41, 50, 59, and 66 shall be completed by Hospital-Based Providers only. The purpose of these lines shall be to compute each ancillary cost center's share of plant operations and maintenance, housekeeping and capital costs. The Column 7 amounts are derived by multiplying the appropriate Hospital Ancillary Square Foot Percentage (Schedule F, Statistic B, Column 4) by the amount on Schedule D-4, Line 24, Column 9.

G. Column 8: This column shall be used for reporting the Certified Cost-Based Facility's share of indirect cost. For each ancillary cost center, multiply the appropriate Certified Cost-Based Facility Ancillary Charge Percentage (Schedule F, Statistic D, Column 3) times the amounts reported in Column 7 to arrive at the correct amounts for Column 8.

SCHEDULE D-6-RECLASSIFICATION OF EXPENSES

This work sheet provides for the reclassification of certain amounts necessary to effect proper cost allocation under cost finding. All providers that do not direct cost payroll fringe benefits to individual cost centers shall use this schedule to allocate fringe benefits to the various cost centers. Fringe benefits shall be reclassified to individual cost centers on the ratio of the salaries unless another, more accurate and documentable method can be determined. The reclassification to each cost center shall be entered to the appropriate Schedule D-1 through D-5 line titled " Employee Benefits Reclassification."

SCHEDULE D-7-ADJUSTMENT TO EXPENSES

This schedule details the adjustments to the expenses listed on Schedule D-1 through D-5, column 4. Line descriptions indicate the nature of activities which affect allowable costs as defined in this manual or result in costs incurred for reasons other than patient care, and thus require adjustment. Lines 22 through 52 are provided for other adjustments not specified earlier. A brief description shall be provided.

The adjusted amount entered in Schedule D-7, column 3, shall be noted "A" in Schedule D-7, column 2, when the adjustment is based on costs. When costs are not determinable, "B" shall be entered in column 2 to indicate that the revenue received for the service is the basis for the adjustment.

SCHEDULE E - ANCILLARY SETTLEMENT

This schedule is designed to determine the Medicaid share of direct and indirect ancillary costs.

A. Column 2: Enter direct ancillary cost for each ancillary cost center from Schedule D-5, Column 6.

B. Column 3: Multiply the direct costs (Column 2) by the corresponding Medicaid charge percentages (Schedule F, Section D, Column 5, Lines 1 through 7).

C. Column 4: Enter the total amount received from the Medicaid Program (including any amount receivable from the Medicaid Program at the report date) for

ancillary services rendered to Medicaid Certified Cost-Based Facility recipients during the period covered by the cost report.

D. Column 5: Subtract the Column 5 amount from the Column 4 amount and enter the difference in Column 6.

SCHEDULE F - ALLOCATION STATISTICS

A. Section A - Nursing Hours or Salaries

This allocation statistic shall be used as the basis for allocating the line item costs reported to Schedule D-1, Lines 1-33; Schedule D-2, Lines 1-30; and D-3, Lines 57-130 which cannot be direct costed to the levels of care. The allocation statistic may be based on the ratio of direct cost of nursing salaries, the ratio of direct nursing hours, a valid time study (as defined by the Department for Medicaid Services), another method which has been approved by the Department for Medicaid Services or, if no other reasonable basis can be determined, patient days. The computation of this statistic shall account for the direct salary costs associated with all material non-certified nursing activities of the facility (such as adult day care or home health services, for example). The computed statistic shall be reasonable and based on documented data. The method used in arriving at the allocation shall be identified at the appropriate place on Schedule F, Ratio A.

For Hospital-Based Facilities Only: The salary costs of all departments and services of the hospital, including all ancillary departments as defined in the general policies and principles of the Department for Medicaid Services, shall be

included in the calculation of this statistic. Allocations of costs between Certified Cost-Based Facility and acute cost centers on the basis of patient days will be accepted only when the resulting allocation statistic can be documented and shown to be reasonable.

1. Line 1: Enter the Certified Cost-Based Facility figure (i.e., salaries or direct hours)
2. Line 2: Enter the "Other" nursing and direct service figure (i.e. salaries or direct hours)
3. Line 3: Divide Line 1 by the sum of Lines 1 and 2 and enter the percentage on Line 3. The percentage shall be carried out to four decimal places (i.e. xx.xxxx%).
4. NOTE: If salary cost figures are used in computing this allocation statistic, the amounts entered in Lines 1 and 2 shall usually agree to entities on the salary lines of Schedule D-1. If the Schedule F, Ratio A salary figures do not agree to Schedule D-1 salary lines, providers shall review both schedules to ensure that both schedules are correct. The provider shall be able to reconcile Schedule F, Ratio A to Schedule D-1 salary lines upon request.

B. Section B - Square Footage

1. Free standing facilities shall only complete Columns 1 and 2 of this section. Hospital facilities shall complete all four columns.

a. Column 1, Lines 1-10: Enter the square feet in each applicable area of the facility. Direct patient room areas shall be allocated between Certified Cost-Based Facility and "Other" (PC, Non-certified, Acute, etc.). General patient areas, such as hallways, nursing stations, lounges, etc., which are utilized 100% by one level of care shall be directly allocated to the appropriate cost center. General patient areas used by more than one level of care and general service departments (administrator offices, dietary areas, etc.,) shall be allocated between levels of care based on the ratio of Certified Cost-Based Facility room square footage to total room square footage. In free-standing facilities, ancillary departments shall be considered general service departments and allocated to levels of care. In Hospital-Based facilities, direct ancillary square footage shall be entered on Lines 3 through 8.

b. Column 2, Lines 1-10: Percentages in Column 2 shall be derived by dividing Column 2, Lines 1 through 9, by Line 10 of Column 1. Line 10 shall be the sum of Lines 1 through 9 and should equal 100.0000%.

2. Columns 3 and 4 shall only be completed by Hospital-Based Facilities. These two columns compute allocation factors to allocate the indirect ancillary costs allocated to the pooled ancillaries in Column 9 of

Schedules D-3 and D-4 to the individual ancillary cost centers on Schedule D-5.

a. Column 3, Lines 3-9: The entries to these lines shall be identical to the entries on the same line number of Ratio B, Column 1.

b. Column 3, Line 10: The entry to this line shall be the sum of the entries to Lines 3-9.

c. Column 4, Lines 3-9: The entries to these lines shall be the percentages resulting from dividing the direct square footage allocated to each ancillary service in Column 3, Lines 3-9 by the total direct ancillary square footage computed at Column 3, Line 10. Percentages shall be carried to four digits (i.e., xx.xxxx%).

d. Column 4, Line 10: The entry to this line shall be the sum of Column 4, Lines 3-9 and shall equal 100.0000%.

C. Section C - Dietary

Identify the method used in arriving at the number of meals served. An actual meal count for 3 X inpatient days shall be used. If 3 X inpatient days is used, the provider shall ensure that bed reserve days are not included in this calculation.

1. Column 1: Enter total meals in each category.

2. Column 2: To arrive at percentages, divide Lines 1 and 2 in Column 1 by Line 3 in Column 1.

D. Section D - Ancillary Charges

1. Column 1: Enter the total charges for each type of ancillary service on Lines 1 through 7. Add Lines l through 7 and enter total on Line 8.

2. Column 2: Enter the total charge for each type of ancillary service provided to all Certified Cost-Based Facility patients (both Medicaid and non-Medicaid) on Lines 1 through 7. Add Lines 1 through 7 and enter the sum to Line 8.

3. Column 3: For each Line 1 through 8 divide total CNF patient charges as reported in Column 2 by the total patient charges (all facility patients) reported in Column 1. Enter the resulting percentage in column 3. Percentages shall be carried to four decimal places (i.e., xx.xxxx%).

4. Column 4: Enter the total charges for each type of ancillary service provided to Medicaid patients in certified beds on Lines 1 through 7. Add Lines 1 through 7 and total on Line 8.

5. Column 5: For each Line 1 through 8 divide Medicaid charges in Column 4 by total charges in Column 1. Enter the resulting percentage in Column 3. Percentages shall be carried out to four decimals (i.e. xx.xxxx%).

E. Section E - Occupancy Statistics

1. Lines 1 and 2. Enter the number of licensed bed days. Temporary changes due to alterations, painting, etc. do not affect bed capacity.

2. Line 3. Total licensed bed days available shall be determined by multiplying the number of licensed beds in the period by the number of days in the period. Take into account increases and decreases in the

number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, actual bed days shall be used.

3. Line 4. Enter patient days for all patients in the facility. A patient day shall be the care of one patient during the period between one census taking period on two successive days, including bed reserve days. The day of admission shall be included and the day of discharge excluded. Do not include both. When a patient is admitted and discharged on the same day, this period shall be counted as one day.

4. Line 5. Percentage of occupancy shall be the percentage obtained by dividing total patient days by bed days available. The percentage calculation shall not be carried beyond one decimal place (xx.x%).

5. Line 6. A Medicaid patient day of care shall be an inpatient or bed reserve day covered under the Medicaid Program. A patient days covered by the Medicare Program for which a co-insurance or deductible is made by the Medicaid Program shall not be considered a Medicaid day.

6. Line 7. The percentage of Medicaid occupancy shall be Medicaid

COMMONWEALTH OF KENTUCKY

Cabinet for Health Services

Department for Medicaid Services

COST-BASED FACILITY

COST REPORT

Edition 4/00

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For The Period from _____ Status _____
to _____ Leap Year ☐ 365 ☐

A. Type of Control

1. Voluntary Non-Profit
   - Church ☐
   - Other(Specify) ☐
   - _____
   - _____
2. Proprietary
   - Individual ☐
   - Partnership ☐
   - Corporation ☐
   - Other(Specify ☐
   - _____
   - _____
3. Government
   - ☐ State _____
   - ☐ County _____
   - ☐ City _____
   - ☐ Other(Specify)
   - _____
   - _____

B. Statement of costs of services from Related Organizations

1. In the amount of costs to be reimbursed by the MEDICAID Program, are any costs included which are the result of transactions with a related organization?

   Yes ☐ No ☐ (If "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Costs incurred as the result of transactions with related organizations.

Schedule	Line #.	Item	Amount

D. Name & percent of direct or indirect ownership of the related organization.

Name of Owner	Name of Related Organization	Percent

E. Statement of Compensation of Owners

Name	Title & Function	Percent of Customary Work Week Devoted to Business	Partners % of Operating Profit or Loss	Corp. Off. % of Vendor's Stock Owned	Total Compensation

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For The Period from _____
to _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

Name	Title	Percent of Customary Work Week Devoted to Business	Percent of Period Employed	Total Compensation for the Period

G. Has the facility had a change of ownership in the past fiscal year?
A change of ownership is defined as the transfer of assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes ☐ No ☐

If yes, indicate the new owners and the percent owned. (If corporate owned, list individuals.)

Name	Percent Owned

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended
and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of
in accordance with applicable program directives, except as noted.

(Signed) _____
Officer or Administrator of Facility

_____
Title

ANNUAL COST REPORT
SCHEDULE B
STATEMENT OF INCOME AND EXPENSES

VENDOR NAME: ENDOR NUMBER FYE

1. Total Patient Revenues		
2. Less: Allowances and discounts on patients' accounts		
3. Net Patient Revenues		$ -
4. Less: Total operating expenses		
5. Net income from services to patients		$ -
OTHER INCOME		
6a. Unrestricted contributions, donations, bequests, etc.		
6b. Restricted contributions, donations, bequests, etc.		
7a. Income from unrestricted investments		
7b. Income from restricted investments		
8. Vending machine commission		
9. Revenue from meals sold to employees and guests		
10. Revenue from sale of drugs, supplies, etc., sold to non-patients		
11. Revenue from telephone and telegraph service		
12. Revenue from rental of non-patient facilities		
13. Revenue from Beauty/Barber Shop		
14. Purchase discounts		
15. Other (specify)		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31. Total other income		-
32. Total of line 5 and line 31		-
OTHER EXPENSES (Specify)		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		
49. Total other expenses		
50. NET INCOME FOR THE PERIOD (line 32 less line 49)		

ANNUAL COST REPORT
SCHEDULE C
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

ASSETS

		(1) Per Books	(2) Adjustments	(3) Balance
	Current Assets			
1.	Cash			$ -
2.	Notes and Accounts Receivable			$ -
3.	Other Receivables			$ -
4.	Less: Allowance for Uncollectable Accounts			$ -
5.	Inventory			$ -
6.	Prepaid Expenses			$ -
7.	Investments			$ -
8.	Other (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
9.	*Total Current Assets*	$ -	$ -	$ -
	Fixed Assets			
10.	Land			$ -
11.	Building and Leasehold Improvements			$ -
12.	Less: Accumulated Depreciation			$ -
13.	Fixed Equipment			$ -
14.	Less: Accumulated Depreciation			$ -
15.	Major Movable Equipment			$ -
16.	Less: Accumulated Depreciation			$ -
17.	Motor Vehicles			$ -
18.	Less: Accumulated Depreciation			$ -
19.	Minor Equipment			$ -
20.	Less: Accumulated Depreciation			$ -
21.	*Total Fixed Assets*	$ -	$ -	$ -
	Other Assets			
22.	Investments			$ -
23.	Lease Deposits			$ -
24.	Due from Owners or Officers (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
25.	Other (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
26.	*Total Other Assets*	$ -	$ -	$ -
27.	Total Assets	$ -	$ -	$ -

ANNUAL COST REPORT
SCHEDULE C (cont.)
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

		(1)	(2)	(3)
	LIABILITIES			
	Current Liabilities	**Per Books**	**Adjustments**	**Balance**
28.	Accounts Payable			$ -
29.	Notes Payable			
30.	Current Portion of Long Term Debt			
31.	Salaries and Fees Payable			
32.	Payroll Taxes Payable			
33.	Income Taxes Payable			
34.	Deferred Income Payable			
35.	Other (Specify)			
36.	*Total Current Liabilities*	$ -	$ -	$ -
	Long Term Liabilities			
37.	Mortgage Payable			$ -
38.	Notes Payable			
39.	*Total Long Term Liabilities*	$ -		$ -
40.	**Total Liabilities**	$ -	$ -	$ -
	CAPITAL AND OWNERS' EQUITY			
41.	Common Stock			$ -
42.	Preferred Stock			
43.	Treasury Stock			
44.	Retained Earnings			
45.	Other (Specify)			
46.	**Total Capital and Owners' Equity**	$ -	$ -	$ -
47.	**Total Liabilities and Capital**	$ -	$ -	$ -

ANNUAL COST REPORT
SCHEDULE C-1
BALANCE SHEET AND EQUITY CAPITAL ADJUSTMENTS

VENDOR NAME: VENDOR NUMBER: FYE

ITE	EXPLANATION	AMOUNT	CLASSIFICATION ADJUSTED ACCOUNT	LINE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
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42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56	TOTAL	$ -		

ANNUAL COST REPORT -- SCHEDULE D-1 -- NURSING SERVICES COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloc. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloc. of Costs
1	Director of Nursing Salary							
2	R.N. Salaries							
3	L.P.N. Salaries							
4	C.M.A. Salaries							
5	Aides Salaries							
6	Other Salaries_							
7	Other Salaries_							
8	Other Salaries_							
9	*Subtotal-Salaries*							
10	Employee Benefits Reclassification							
11	Nursing Contracted Services							
12	Medical Records Salaries							
13	Medical Director Fees							
14	Pharmacy Consultant Fees							
15	Physician Services							
16	Nursing Education & Training							
17	Nursing Travel Expense							
18	Medical Supplies							
19	Adult Diapers & Underpads							
20	Nursing Equipment Rental							
21	Nursing Small Equip. Purchases							
22	Other Expense_							
23	Other Expense_							
24	Other Expense_							
25	Other Expense_							
26	Other Expense_							
27	Other Expense_							
28	Other Expense_							
29	Other Expense_							
30	Other Expense_							
31	Other Expense_							
32	Other Expense_							
33	Other Expense_							
34	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-2 -- OTHER CARE RELATED COSTS

VENDOR NAME: VENDOR NUMBER: FYE

(1) Care Related	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Allocn. of Costs	(8) Non-Certified & Non-Nursing Fac. Allocn. of Costs
1 Activities Salaries							
2 Social Services Salaries							
3 Other Salaries_							
4 Other Salaries_							
5 Other Salaries_							
6 *Subtotal-Salaries*							
7 Employee Benefits Reclassification							
8 Activities Supplies							
9 Social Services Supplies							
10 Training & Education Expense							
11 Travel Expense							
12 Other Expense_							
13 Other Expense_							
14 Other Expense_							
15 Other Expense_							
16 Other Expense_							
17 Other Expense_							
18 Other Expense_							
19 Other Expense_							
20 Other Expense_							
21 Other Expense_							
22 Other Expense_							
23 Other Expense_							
24 Other Expense_							
25 Other Expense_							
26 Other Expense_							
27 Other Expense_							
28 Other Expense_							
29 Other Expense_							
30 Other Expense_							
31 Raw Food							
32 *Total*							

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
	Dietary								
1	Dietary Salaries								
2	Other Salaries_								
3	Other Salaries_								
4	Other Salaries_								
5	*Subtotal-Salaries*								
6	Employee Benefits Reclassification								
7	Dietary Consultant Fees								
8	Dietary Supplies								
9	Equipment Rental								
10	Small Equipment Purchases								
11	Other Dietary Expense_								
12	Other Dietary Expense_								
13	Other Dietary Expense_								
14	Other Dietary Expense_								
15	Other Dietary Expense_								
16	Other Dietary Expense_								
17	Other Dietary Expense_								
18	Other Dietary Expense_								
19	Other Dietary Expense_								
20	*Total Dietary Expense*								
	Housekeeping & Plant Operation								
21	Housekeeping Salaries								
22	Plant Oper. & Maint. Salaries								
23	Other Salaries_								
24	Other Salaries_								
25	Other Salaries_								
26	*Subtotal-Salaries*								
27	Employee Benefits Reclassification								
28	Housekeeping Supplies								
29	Plant Oper. & Maint. Supplies								
30	Equipment Rental								
31	Repairs & Maintenance-Building								

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
32 Repairs & Maintenance-Equipment								
33 Repairs & Maintenance-Grounds								
34 Small Equipment Purchases								
35 Gas								
36 Electricity								
37 Water & Sewage								
38 Garbage Pick-up								
39 Contracted Services								
40 Pest Control Services								
41 Property Taxes								
42 Insurance-Property, Plant & Equip.								
43 Other Hskg. & Plant Op._								
44 Other Hskg. & Plant Op._								
45 Other Hskg. & Plant Op._								
46 Other Hskg. & Plant Op._								
47 Other Hskg. & Plant Op._								
48 Other Hskg. & Plant Op._								
49 Other Hskg. & Plant Op._								
50 Other Hskg. & Plant Op._								
51 Other Hskg. & Plant Op._								
52 Other Hskg. & Plant Op._								
53 Other Hskg. & Plant Op._								
54 Other Hskg. & Plant Op._								
55 Other Hskg. & Plant Op._								
56 *Total Housekeeping & Plant Oper.*								
Laundry								
57 Laundry Salaries								
58 Other Salaries_								
59 Other Salaries_								
60 Other Salaries_								
61 *Subtotal-Salaries*								
62 Employee Benefits Reclassification								
63 Laundry Supplies								
64 Linens & Bedding								

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Allocn. of Costs	(8) Non-Certified & Non-Nursing Fac. Allocn. of Costs	(9) Ancillary Hospital-Based Facility Only
65	Laundry Contracted Services								
66	Other Laundry Expense_								
67	Other Laundry Expense_								
68	Other Laundry Expense_								
69	Other Laundry Expense_								
70	Other Laundry Expense_								
71	Other Laundry Expense_								
72	Other Laundry Expense_								
73	Other Laundry Expense_								
74	Other Laundry Expense_								
75	*Total Laundry Expense*								
	Administrative & General								
76	Salaries-Officers								
77	Salaries-Administrator								
78	Salaries-Office Staff								
79	Other Salaries_								
80	Other Salaries_								
81	Other Salaries_								
82	*Subtotal-Salaries*								
83	Management Fees								
84	Home Office Costs								
85	Board of Directors Fees								
86	FICA								
87	Workmen's Compensation								
88	Unemployment Insurance								
89	Medical Insurance								
90	Life Insurance								
91	Telephone								
92	Dues & Subscriptions								
93	Office Supplies								
94	Equipment Rental								
95	Printing & Postage								
96	Legal Fees								
97	Accounting Fees								

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

Edition 4/00

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
98 Contracted Services								
99 Utilization Review								
100 Travel & Seminars								
101 Advertising-Help Wanted								
102 Advertising-Other								
103 Small Equipment Purchases								
104 Licenses & Fees								
105 Interest Expense-Non-Capital								
106 Other Expense_								
107 Other Expense_								
108 Other Expense_								
109 Other Expense_								
110 Other Expense_								
111 Other Expense_								
112 Other Expense_								
113 Other Expense_								
114 Other Expense_								
115 Other Expense_								
116 Other Expense_								
117 Other Expense_								
118 Other Expense_								
119 Other Expense_								
120 Other Expense_								
121 Other Expense_								
122 Other Expense_								
123 Other Expense_								
124 Other Expense_								
125 Other Expense_								
126 Other Expense_								
127 Other Expense_								
128 Other Expense_								
129 Other Expense_								
130 HEALTH CARE PROVIDER TAX								
131 *Total Admin. & General Exp.*								

ANNUAL COST REPORT -- SCHEDULE D-4 -- CAPITAL COSTS

VENDOR NAME: VENDOR NUMBER: FYE

Edition 4/00

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
1	Depreciation-Building								
2	Depreciation-Equipment								
3	Interest Expense-Capital Related								
4	Rent								
5	Land Improvements								
6	Leasehold Improvements								
7	Amortization of Start-up Costs								
8	Other Capital Costs_								
9	Other Capital Costs_								
10	Other Capital Costs_								
11	Other Capital Costs_								
12	Other Capital Costs_								
13	Other Capital Costs_								
14	Other Capital Costs_								
15	Other Capital Costs_								
16	Other Capital Costs_								
17	Other Capital Costs_								
18	Other Capital Costs_								
19	Other Capital Costs_								
20	Other Capital Costs_								
21	Other Capital Costs_								
22	Other Capital Costs_								
23	*Total*								

	Grand Totals	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
24	Totals of Schedules D-1 through D-4								
25	Total of Schedule D-5, Column 8								
26	Total Routine CNF Cost								
27	Totals from Schedule D-5								
28	Total Cost								

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Physical Therapy							
1	Physical Therapist Salaries							
2	Physical Therapist Asstnts. Salaries							
3	Physical Therapist Aides Salaries							
4	Other Salaries_							
5	*Subtotal-Salaries*							
6	Employee Benefits Reclassification							
7	Contracted Services							
8	Equipment Depreciation							
9	Other Expenses_							
10	Other Expenses_							
11	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col. 4)						
12	*Total*							
	X-Ray							
13	Professional Salaries							
14	Other Salaries_							
15	*Subtotal-Salaries*							
16	Employee Benefits Reclassification							
17	Supplies							
18	Equipment Depreciation							
19	Other Expenses_							
20	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)						
21	*Total*							
	Laboratory							
22	Professional Salaries							
23	Other Salaries_							
24	*Subtotal-Salaries*							
25	Employee Benefits Reclassification							
26	Supplies							
27	Equipment Depreciation							
28	Other Expenses_							
29	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)						
30	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Oxygen/Respiratory Therapy							
31	Respiratory Therapist Salaries							
32	Respiratory Therapist Assistant Sal							
33	Respiratory Therapist Aides Salaries							
34	Other Salaries_							
35	*Subtotal-Salaries*							
36	Employee Benefits Reclassification							
37	Supplies							
38	Equipment Depreciation							
39	Other Expenses_							
40	Other Expenses_							
41	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 6, Col. 4)						
42	*Total*							
	Speech							
43	Professional Salaries							
44	Other Salaries_							
45	*Subtotal-Salaries*							
46	Employee Benefits Reclassification							
47	Equipment Depreciation							
48	Other Expenses_							
49	Other Expenses_							
50	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 7, Col. 4)						
51	*Total*							
	Other							
52	Professional Salaries							
53	Other Salaries_							
54	*Subtotal-Salaries*							
55	Employee Benefits Reclassification							
56	Equipment Depreciation							
57	Other Expenses_							
58	Other Expenses_							
59	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 8, Col. 4)						
60	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Drugs							
61	Pharmicist Salaries							
62	Other Salaries_							
63	*Subtotal-Salaries*							
64	Employee Benefits Reclassification							
65	Drugs							
66	Equipment Depreciation							
67	Other Expenses_							
68	Other Expenses_							
69	Other Expenses_							
70	Other Expenses_							
71	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9, X Sch. F, Section B, Line 9, Col. 4)						
72	*Total*							

SCHEDULE D-6
RECLASSIFICATIONS OF EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

Line	(1) Explanation	(2) Increase Amount	(3) Decrease Amount	(4) Cost Center Affected (Schedule & Line # Affected) (e.g. D3-1)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
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46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				
57				
58				
59				
60				
61	*Total*			

SCHEDULE D-7
ADJUSTMENTS TO EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

Line	(1) Explanation	(2) * Basis for Adjustment (A) or (B)	(3) Amount	(4) Sch. & Line # Affected (e.g. D3-1)
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts & Income Designated by the donor for a specific purpose			
5	Beauty & Barber Shop **			
6	Excess Owners Compensation			
7	Telephone Serv.(Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of Drugs to other than Patients			
11	Sale of Medical & Surgical Supplies to other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Emp. & Others			
15	Rental of Facility Space			
16	Trade, Qty, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss on Disposition of Assets			
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53	*Total*			

* (A) COST (B) REVENUE

** *Beauty & Barber Shop Revenues in excess of Beauty & Barber Shop supply & personnel cost is to be adjusted in an Administrative & General cost center.*

ANNUAL COST REPORT -- SCHEDULE E -- ANCILLARY SETTLEMENT

VENDOR NAME: VENDOR NUMBER:

FYE

(1)	(2) Direct (From Sch. D-5, Col.6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable To KMAP)
1 Physical Therapy				
2 X-Ray				
3 Laboratory				
4 Oxygen/Respiratory Therapy				
5 Speech				
6 Other				
7 Drugs				
8 *Total*				

Medicaid Services use only.
TENTATIVE ANCILLARY ☐
ANCILLARY SETTLEMNT ☐

Edition 4/00

ANNUAL COST REPORT

SCHEDULE F

ALLOCATION STATISTICS

VENDOR NAME: _____ FYB _____ FYE _____

Status VENDOR NUMBER: _____ DAYS MONTHS

A. NURSING SALARIES

Leap Year ☐ 365 ☐

1. CERTIFIED NURSING FACILITY _____
2. OTHER _____
3. CERT. NURSING FAC. PERCENTAGE _____

ALLOCATION METHOD:

PATIENT DAYS ☐ VALID TIME STUDY ☐

DIRECT COST ☐ DIRECT HOURS ☐

OTHER APPROVED METHOD ☐

B. SQUARE FOOTAGE

	(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) HOSPITAL-BASED PERCENT
1. CERT. NURSING FACILITY				
2. OTHER				
3. PHYSICAL THERAPY *				
4. X-RAY *				
5. LABORATORY *				
6. OXYGEN/RESP. THERAPY *				
7. SPEECH *				
8. OTHER *				
9. DRUGS *				
10. TOTAL				

* For Hospital-Based Certified Nursing Facility Only

C. DIETARY

	(1) MEALS	(2) PERCENT
1. CERT. NURSING FACILITY		
2. ALL OTHER		
3. TOTAL		

ALLOCATION METHOD:

MEAL COUNT: ☐ 3 * INPATIENT DAYS: ☐

D. ANCILLARY CHARGES

	(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID %
1. PHYSICAL THERAPY					
2. X-RAY					
3. LABORATORY					
4. OXYGEN/RESP. THERAPY					
5. SPEECH					
6. OTHER					
7. DRUGS					
8. TOTAL					

E. OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1. LICENSED BEDS AT BEGINNING OF PERIOD			
2. LICENSED BEDS AT END OF PERIOD			
3. BED DAYS AVAILABLE			
4. TOTAL PATIENT DAYS			
5. % OCCUPANCY			
6. KMAP PATIENT DAYS			
7. % KMAP OCCUPANCY			

F. ADDITIONAL STATISTICS

1. DIRECT ROUTINE NURSING HOURS - CERTIFIED NURSING FACILITY ONLY	
2. TOTAL DIRECT DIETARY HOURS	
3. TOTAL DIRECT HOUSEKEEPING HOURS	

Edition 4/00

KMAP-2

SUPPLEMENTAL MEDICAID SCHEDULE

COMPUTATION OF DUAL LICENSED ANCILLARY COST

VENDOR NAME: _____ VENDOR NUMBER: _____

FYB _____ FYE _____ DAYS

Leap Year ☐ 365 ☐

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41. RADIOLOGY-DIAGNOSTIC												
42. RADIOLOGY-THERAPEUTIC												
43. RADIOISOTOPE												
44. LABORATORY												
45. PBP CLINIC LAB SVC-PRG. ONLY												
46. WHOLE BL. & PK. RED BL. CELLS												
48. IV THERAPY												
49. RESPIRATORY THERAPY												
50. PHYSICAL THERAPY												
51. OCCUPATIONAL THERAPY												
52. SPEECH PATHOLOGY												
53. ELECTROCARDIOLOGY												
54. ELECTROENCEPHALOGRAPHY												
55. MED. SUPPLIES CHG. TO PT.												
56. * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING) _____

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104) _____

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-89, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-89, WORKSHEET C, COL. 8
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MULTIPLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND CHARGES PRIOR TO OCTOBER 1, 1990 ONLY

KMAP-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

VENDOR NAME:

VENDOR NUMBER:

FYB FYE DAYS

*1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
*4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
*7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 - Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from KMAP-2 Line 101, Column 12
14. Line 12 plus line 13. Transfer this amount to HCFA 2552-89, worksheet E-3, Part III, line 7A

* Effective for services provided after October 1, 1990

DISCLOSURE SECTION

VENDOR NAME: ______________________ FYE ________

VENDOR NUMBER: ________

A: STATEMENT OF ORGANIZATIONS CONTRACTED WITH

NAME	TYPE OF BUSINESS	DATE OF CONTRACT		

B: PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

ITEM	AMOUNT			SCHEDULE AND LINE		